Eastside Integrated Primary Care
13353 Bel-Red Rd, Ste 105
Bellevue, Washington, US - 98005-2329

New Patient Intake Form

Personal Details

First Name *

Last Name *

Date of Birth *

Gender ☐ Male ☐ Female ☐ Unknown

Blood Group

Language

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed ☐ Retired

Marital Status ☐ Single ☐ Married ☐ Others

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker ☐ Smoker ☐ current status unknown ☐ Unknown if ever smoked

Primary Contact Details

Caregiver First Name

Caregiver Last Name

Email *

Home Phone

Mobile Phone

Work Phone

Fax

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 *

Address Line2

City *

Country *

State *

Zip code *

Postbox No

Emergency Contact Name

Emergency Contact Number

Extn

Screenings:

Date of your last annual physical exam

Date of your last dental visit

Date of your last eye appointment

Date of your last colonoscopy/colon cancer screening stool testing (for ages 45 and up)

Date of your last mammogram (if applicable)

Date of your last PAP Smear/Well Woman Exam (if applicable)

Date of your last bone density scan (if applicable)

Dermatology visit

Allergies

Allergies	Type	Severity	Reactions

Supplements

Supplement Name	Intake Details

Medications

Medication Name	Intake Details

Chief Complaint: *

Past Medical History *

- ☐ N/A
- ☐ Allergies/Hay Fever
- ☐ Autoimmune disease (Please specify in “other”)
- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ COVID-19
- ☐ Prediabetes
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Alcoholism
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Dizziness/Fainting
- ☐ Shortness of Breath
- ☐ Esophageal Stricture
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Heart Palpitations
- ☐ Arrhythmia
- ☐ Orthopnea
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Claudication
- ☐ Liver Disease/Hepatitis
- ☐ Chest Pain/Angina
- ☐ GI Disorder
- ☐ Kidney Disease
- ☐ Sexual Dysfunction
- ☐ Urinary Disorder
- ☐ Menstrual Dysfunction
- ☐ Venereal Disease
- ☐ Colon Polyps
- ☐ Stroke/TIA
- ☐ Endocrine Disease
- ☐ Congenital Heart Disease
- ☐ Ulcer
- ☐ COPD
- ☐ Anemia
- ☐ Anxiety
- ☐ Epilepsy
- ☐ Gout
- ☐ Gallbladder Issue
- ☐ Heart Attack
- ☐ Asthma
- ☐ Cancer (Please specify in "other" which type)

Hospitalization/Surgical History/Imaging (Please state month/year): *

Family History:

Mother - *

- ☐ Asthma
- ☐ Alzheimers
- ☐ Hypertension
- ☐ Colon Cancer
- ☐ Colorectal Polyps
- ☐ Diabetes Type II
- ☐ Liver Disease
- ☐ Rheumatoid Arthritis
- ☐ Depression
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Stroke
- ☐ Lung Cancer
- ☐ Glaucoma
- ☐ Epilepsy
- ☐ Kidney Disease
- ☐ Other type of arthritis (please specify in "other")
- ☐ Unknown
- ☐ Dementia
- ☐ High Cholesterol
- ☐ Breast Cancer
- ☐ Other Cancer (Please specify in "other")
- ☐ Diabetes Type I
- ☐ Gastrointestinal Disease (Please specify in 'other")
- ☐ Osteoarthritis
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Anxiety

Father - *

- ☐ Asthma
- ☐ Dementia
- ☐ Hypertension
- ☐ Colon Cancer
- ☐ Colorectal Polyps
- ☐ Diabetes Type II
- ☐ Liver Disease
- ☐ Rheumatoid Arhritis
- ☐ Unknown
- ☐ Heart Disease
- ☐ Alzheimers
- ☐ Stroke
- ☐ Lung Cancer
- ☐ Glaucoma
- ☐ Epilepsy
- ☐ Kidney Disease
- ☐ Other type of arthritis (please specify in "other"
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Breast Cancer
- ☐ Other Cancer (Please specify in "other"
- ☐ Diabetes Type I
- ☐ Gastrointestinal Disease
- ☐ Osteoarthritis
- ☐ Thyroid disease
- ☐ Anxiety
- ☐ Depression

Maternal Grandmother - *

- ☐ Asthma
- ☐ Dementia
- ☐ Hypertension
- ☐ Colon Cancer
- ☐ Colorectal Polyps
- ☐ Diabetes Type II
- ☐ Liver Disease
- ☐ Rheumatoid Arthritis
- ☐ Depression
- ☐ Heart Disease
- ☐ Alzheimers
- ☐ Stroke
- ☐ Lung Cancer
- ☐ Glaucoma
- ☐ Epilepsy
- ☐ Kidney Disease
- ☐ Other type of arthritis (please specify in "other")
- ☐ Unknown
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Breast Cancer
- ☐ Other Cancer (Please specify in "other")
- ☐ Diabetes Type I
- ☐ Gastrointestinal Disease (Please specify in 'other")
- ☐ Osteoarthritis
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Anxiety

Paternal Grandmother - *

- ☐ Asthma
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Dementia
- ☐ Alzheimers
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Stroke
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Other Cancer (Please specify in "other")
- ☐ Colorectal Polyps
- ☐ Glaucoma
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Epilepsy
- ☐ Gastrointestinal Disease (Please specify in 'other")
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Other type of arthritis (please specify in "other")
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Anxiety
- ☐ Depression
- ☐ Unknown

Maternal Grandfather - *

- ☐ Asthma
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Dementia
- ☐ Alzheimers
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Stroke
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Other Cancer (Please specify in "other")
- ☐ Colorectal Polyps
- ☐ Glaucoma
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Epilepsy
- ☐ Gastrointestinal Disease (Please specify in 'other")
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Other type of arthritis (please specify in "other")
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Anxiety
- ☐ Depression
- ☐ Unknown

Paternal Grandfather - *

- ☐ Asthma
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Dementia
- ☐ Alzheimers
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Stroke
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Other Cancer (Please specify in "other")
- ☐ Colorectal Polyps
- ☐ Glaucoma
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Epilepsy
- ☐ Gastrointestinal Disease (Please specify in 'other")
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Other type of arthritis (please specify in "other")
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Anxiety
- ☐ Depression
- ☐ Unknown

Sister - *

- ☐ Asthma
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Dementia
- ☐ Alzheimers
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Stroke
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Other Cancer (Please specify in "other")
- ☐ Colorectal Polyps
- ☐ Glaucoma
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Epilepsy
- ☐ Gastrointestinal Disease (Please specify in 'other")
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Other type of arthritis (please specify in "other")
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Anxiety
- ☐ Depression
- ☐ Unknown
- ☐ N/A

Brother - *

- ☐ Asthma
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Dementia
- ☐ Alzheimers
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Stroke
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Lung Cancer
- ☐ Other Cancer (Please specify in "other")
- ☐ Colorectal Polyps
- ☐ Glaucoma
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Epilepsy
- ☐ Gastrointestinal Disease (Please specify in 'other")
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Other type of arthritis (please specify in "other")
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Anxiety
- ☐ Depression
- ☐ Unknown
- ☐ N/A

Social History:

Relationship Status/Living Situation *

Occupation *

Recreational Drug Use * ☐ Yes ☐ No

If yes to the above, please let us know type/amount/frequency

Dietary Restrictions? * ☐ Yes ☐ No

If so - what are your dietary restrictions?

Breakfast (please report a typical meal for you) *

Lunch (please report a typical meal for you) *

Dinner (please report a typical meal for you) *

Do you use any nicotine containing products? * ☐ Yes ☐ No

If you do use nicotine products, what kind? ☐ Cigarettes ☐ Cigars ☐ Vaping ☐ Chewing ☐ Nicotine Patch

Please list quantity and duration of how long you have been using the nicotine containing product(s)

Approximately how much water do you drink per day (in fl oz or liters)? *

Do you consume caffeine? * ☐ Yes ☐ No

If the answer to the above is yes -- please let us know type/amount/frequency

Do you consume alcohol? * ☐ Yes ☐ No

If the answer above is yes -- please let us know type/amount/frequency.

Difficulty sleeping? * ☐ Yes ☐ No

Continual sleep disturbance? * ☐ Yes ☐ No

Snoring? * ☐ Yes ☐ No

Early morning awakening? * ☐ Yes ☐ No

Daytime Drowsiness? * ☐ Yes ☐ No

What is your exercise routine? *

How would you describe your bowel movements? (Check all that apply) * ☐ Daily ☐ Loose ☐ Diarrhea ☐ Well formed ☐ Easy to Pass ☐ Difficult to Pass ☐ A few times per week

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PHQ-2 Questionnaire

Over the last 2 weeks, how often have you been bothered by the following problems?

Little interest or pleasure in doing things *

☐ Not at all (0) ☐ Several days (+1) ☐ More than half the days (+2) ☐ Nearly every day (+3)

Feeling down, depressed, or hopeless *

☐ Not at all (0) ☐ Several days (+1) ☐ More than half the days (+2) ☐ Nearly every day (+3)

Miscellaneous Information:

Please list your preferred pharmacy (address, phone number, fax) *

How did you find our clinic?

Do you authorize our staff to leave confidential voicemails with information pertaining to your health with the personal phone number provided in this intake form? *

☐ Yes ☐ No

Do you authorize our staff to leave confidential voicemails with information pertaining to your health with the emergency contact phone number provided in this intake form? *

☐ Yes ☐ No

Date this intake form was filled completed: *

PATIENT SIGNATURE *